MARYLAND MEDICAL ASSISTANCE PROGRAM

OFFICE OF HEALTH SERVICES

DIVISION OF OUTREACH AND CARE COORDINATION

OB/GYN/FAMILY PLANNING SERVICES

PROVIDER MANUAL

July 2007

STATE OF MARYLAND

DHMH

MARYLAND DEPARTMENT OF HEALTH & MENTAL HYGIENE
201 West Preston Street
Baltimore, Maryland 21201
410-767-6750 or 1-800-456-8900
Web site: **www.dhmh.state.md.us**

Martin O'Malley
Governor

John M. Colmers
Secretary

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Section I

INTRODUCTION

A. PURPOSE

The primary purpose of this manual is to provide administrative guidance to providers rendering OB/GYN and family planning services to women enrolled in Maryland Medicaid. The manual provides policy and billing information on services covered under Maryland Medicaid's "fee-for-service" and "HealthChoice" programs. The billing information contained within is pertinent to specific services provided in private practices. Please note that clinics and hospital outpatient departments have different billing codes and forms than those outlined in this manual. **NOTE:** The current version of the OB/GYN/Family Planning Services Provider Manual can be obtained from the Department of Health and Mental Hygiene's web site at www.dhmh.state.md.us/mma/providerinfo/.

This manual supplements the *Maryland Medical Assistance Physicians' Services Provider Fee Manual* and the *CMS-1500 Billing Instructions*. Physicians, Certified Nurse Midwives, and Certified Nurse Practitioners may submit their claims electronically or use the *CMS-1500* to bill Maryland Medicaid. Providers desiring additional information regarding electronic billing should contact the Systems Liaison Unit at 410-767-6940.

CMS-1500 claims should be mailed to:
Medical Assistance Program - Claims
P.O. Box 1935
Baltimore, MD 21203-1935

B. HIPAA PRIVACY

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (*HIPAA*) of 1996 require the use of standard electronic health transactions by health insurance plans; including private, commercial, Medicaid and Medicare; healthcare clearinghouses and healthcare providers. The primary intent of the law is to allow providers to meet the data needs of every insurer electronically with one billing format using standardized healthcare industry data and code sets. *HCPCS* is the specified code set for procedures and services. Additional information on *HIPAA* can be obtained from the Department's web site at www.dhmh.state.md.us/hipaa.

C. NATIONAL PROVIDER IDENTIFIER (NPI)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) included a requirement to adopt standard unique identifiers for health care providers. Providers that conduct any of the HIPAA standard transactions, including electronic claims, eligibility, claim status, or remittance, must obtain an NPI. The NPI is a 10-digit, intelligence-free number that will replace all existing provider identifiers. To obtain an NPI, organizational and individual providers can submit an NPI application either online or by mail. To apply online go to: https://nppes.cms.hhs.gov. or call 1-800-465-3203 to request an application by mail. For more information see www.dhmh.state.md.us/html/hot issues_npi.htm.

Maryland Medicaid is currently collecting provider NPI numbers. Please send a copy of the CMS NPI notification letter to:

Maryland Medical Assistance - Provider Enrollment
201 W. Preston Street, LL3
Baltimore, MD 21201

A copy of the CMS NPI notification letter may also be faxed to the Provider Enrollment department at 410-333-5341.

NOTE: Effective July 30, 2007, providers will use the NPI as the primary identifier when billing Maryland Medicaid. For questions or additional information, contact Provider Enrollment at 410-767-5340.

D. THIRD PARTY RECOVERIES

In general, the Medical Assistance Program is always the payer of last resort. If a recipient is covered by insurance or other third-party benefits, the provider must seek payment from that source first. The only exception to the Medicaid as payer of last resort rule is for the provision of well child (Healthy Kids services) and prenatal care.

E. OVERVIEW

The Maryland Department of Health and Mental Hygiene is committed to ensuring that all women have access to quality obstetrical, gynecological, and family planning services. Over the past several years, the state has greatly expanded Medicaid eligibility for pregnant women through the **Maryland Children's Health Program (MCHP)** and provided enhanced services for this population through the **Maryland Healthy Start Program**. Improved communication between local health departments (LHD), managed care organizations (MCO), and private providers, facilitated by programs such as Administrative Care Coordination and Healthy Start, has reduced some of the barriers to care encountered by pregnant women and women seeking family planning services. The strengthening of established public and private sector partnerships will further reduce access to care barriers for this population.

One of Maryland's goals is to assure that all women have access to high quality prenatal and family planning services regardless of their family income. Your participation in the Medicaid Program is critical to ensuring that all women have access to comprehensive services.

Medicaid, also known as Medical Assistance (MA) is a joint federal and state program authorized under Title XIX of the Social Security Act to provide health and long-term care coverage to low-income individuals and persons in certain categories. The Maryland Department of Health and Mental Hygiene (DHMH) provides Medicaid coverage to individuals determined to be categorically eligible or medically needy.

Medicaid coverage is automatically granted to persons receiving certain other public assistance, such as Supplemental Security Income (SSI), Temporary Cash Assistance (TCA), or Foster Care. Maryland Medicaid also provides similar coverage for moderate to low-income children and pregnant women under the **Maryland Children's Health Program (MCHP)** and **MCHP Premium Program**.

Women in need of medical services and treatment may also be eligible under the **Women's Breast and Cervical Cancer Health Program.** Those in need of primary care and family planning services may be eligible for the **Primary Adult Care Program (PAC).**

Most pregnant women in Medicaid/MCHP receive health care services through Maryland's **HealthChoice Program**. **HealthChoice** is Maryland's statewide mandatory managed care program, which began in 1997. HealthChoice beneficiaries enroll in a managed care organization (MCO) of their choice and select a primary care provider (PCP) to manage their medical care. MCO's participating in the HealthChoice program are responsible for providing the full range of health care services covered by the Medicaid "fee-for-service" program, except for certain Medicaid-covered benefits that are "carved out" and available to enrollees outside the MCO.

The following managed care organizations currently serve Maryland's Medicaid recipients:

- *AMERIGROUP Maryland, Inc.*
- *Diamond Plan*
- *Helix Family Choice*
- *Jai Medical Systems*
- *Maryland Physicians Care*
- *Priority Partners*
- *UnitedHealthcare*

F. PROGRAMS ADMINISTRATION

Under Medicaid's HealthChoice and Acute Care Administration (HCACA), the ***Division of Outreach and Care Coordination*** manages the following programs and services:

- Administrative Care Coordination/Ombudsman Program
- Healthy Start Home Visiting and Care Coordination
- Medicaid Policy for Obstetrical and Family Planning Services
- Maternal and Child Health Services
- Primary Adult Care Program

The *Division of Outreach and Care Coordination* has a team of nurses who serve as regional consultants to local health departments (LHD), managed care organizations (MCO), and providers. Nurse consultant services include:

- ✓ Distribution of applicable administrative and clinical manuals/resources
- ✓ Interpretation of Medicaid health policies and federal/state regulations
- ✓ Staff training on Medicaid standards and procedures
- ✓ Assistance with Medicaid/HealthChoice billing
- ✓ Education of providers about various aspects of HealthChoice and fee-for-service issues

A nurse consultant can be reached by calling 410-767-6750 or 1-800-456-8900.

LHD Administrative Care Coordination Units (ACCU)

The Administrative Care Coordination Unit (ACCU) serves as the single point of entry for referrals to the LHD. The ACCU provides care coordination, short-term case management, education,

and outreach to certain low-income and vulnerable populations. The purpose of these activities is to ensure that persons who are eligible for Medicaid or HealthChoice access needed health care and health-related services and that they use the services appropriately.

The ACCU accepts referrals from primary care providers and MCOs for assistance with bringing non-compliant and high-risk recipients, as defined in the HealthChoice regulations, COMAR 10.09.65.04 and 10.09.66.03, into care. The *Local Health Services Request Form* (DHMH 4582) should be used to refer pregnant/postpartum women and children in need of follow-up to the ACCU of the LHD in the recipient's county of residence.

Providers should refer to their MCO provider manuals for specific instructions regarding the referral process**.** In general, providers should initially contact the MCO outreach and/or case management department to obtain follow-up and outreach assistance.

LHD Ombudsman Program

The HealthChoice Program is required to provide an Ombudsman to assist members who are experiencing a dispute or dissatisfaction with their MCO regarding medical services. The local Ombudsman Program operates under the direction of the HealthChoice and Acute Care Administration's *Complaint Resolution Unit (CRU).* Providers are asked to respond promptly to the CRU staff or LHD Ombudsman when contacted for information about a specific issue. The **HealthChoice Enrollee Action Line (1-800-284-4510)** is available for recipients with inquiries or to request assistance with problems with their MCO. Providers may call the **Provider Hotline (1-800-766-8692)** for assistance with resolving problems related to care access on behalf of recipients.

Appeal Process

Enrollees or you on behalf of the enrollee can Appeal to the State a denial, reduction or termination of medical services by the MCO

- A HealthChoice Enrollee should contact the Enrollee Action Line at the State at 1-800-284-4510 between 7:30 A.M. and 5:30 P.M.
- A PAC enrollee should contact the Enrollee Action Line at the State at 1-800-754-0095 between 7:30 A.M. and 5:30 P.M.
- Providers should contact the Provider Hotline at 1-800-766-8692 between 8:00 A.M. and 5 P.M.
- The Action line will provide information on how to request an appeal through the State's Complaint Resolution Unit.
- The Complaint Resolution Unit will attempt to resolve the appeal with the MCO in 10 business days. If it cannot be resolved in 10 business days, a notice will be sent that gives the enrollee a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review of the appeal. When the review is finished, if the enrollee does not agree with the decision that he/she will receive in writing, another notice will again be sent to the enrollee to request a fair hearing.

The State's Decision on the Appeal

When all of the facts about the MCO appeal have been reviewed by the State, the State will take one of the actions below:

- If the State thinks the MCO should provide the benefit or service, it can order the MCO to do so right away, and the MCO will give the enrollee the benefit or service.

- If the State thinks that the MCO does not have to provide the benefit or service, they will inform the enrollee and the doctor in writing that the State agrees with the MCO.

What Kind of Decisions Can Be Appealed

Examples of decisions made by the State that can be appealed. An enrollee, provider, or representative on behalf of the enrollee can appeal a decision when the State:

- Agrees with the MCO that a benefit or service that the enrollee is receiving should be denied or reduced;
- Agrees with the MCO that a benefit or service is not medically necessary;
- Agrees with the MCO that a benefit or service is not covered by the MCO.

Fair Hearings

To appeal one of the State's decisions, a request is made for the State to file a notice of appeal with the Office of Administrative Hearings on behalf of the enrollee. This will be the appeal against the State. The MCO may appear as witness for the State at the appeal hearing.

The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about the MCO reducing or not giving the enrollee a benefit or service because it (and the State) thinks there is not a medical need for the benefit or service, the Office of Administrative Hearings will set an expedited hearing date from the date the request is filed with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the date the request is filed with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

The Board of Review

If the Office of Administrative Hearings decides against the enrollee, they may appeal to the State's Board of Review. They will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings.

Judicial Appeal

If the Board of Review decides against the enrollee, they may appeal to the Circuit Court.

Transportation Services

The Medicaid Program provides transportation grants to each local jurisdiction to assist clients with transportation to Medicaid covered services. (*Resources, B-4*). The MCO may also provide limited transportation assistance.

Section II

MEDICAID ELIGIBILITY

Most women who receive Medicaid are in one of three eligibility categories: **general Medicaid**, the **Maryland Children's Health Program** (MCHP), formerly known as the Pregnant Women and Children's Program (PWC**)**, or the **Primary Adult Care Program** (PAC). Women are eligible for medical assistance coverage and full health benefits based on qualifying income. The qualifying income amounts change annually based on changes to federal poverty level (FPL) standards.

❖ GENERAL MEDICAID

Women whose family income is at or below 45% of the FPL may apply for general Medicaid. Women who receive benefits under general Medicaid will continue to have their eligibility reviewed every six months, irrespective of pregnancy. These women should be encouraged to contact their local department of social services (LDSS) case worker to ensure that their eligibility is not interrupted during pregnancy and full MA coverage, including family planning services, continues beyond the postpartum period.

❖ THE MARYLAND CHILDREN'S HEALTH PROGRAM (MCHP)

The Maryland Children's Health Program (MCHP) provides full health benefits for children under the age of 19 and pregnant women. Currently, pregnant women whose family income is at or below 250% of the FPL are eligible for health care coverage through MCHP.

Once a pregnant woman is determined eligible for MCHP, she has coverage through the duration of her pregnancy and two months postpartum. Each woman will have a primary care physician. MCHP covers the same services as general Medicaid with the exception of abortions, which, are not covered for pregnant women who enrolled for coverage under MCHP.

❖ THE PRIMARY ADULT CARE PROGRAM (PAC)

The Primary Adult Care (PAC) program, which began July 2006, is a new health care program that covers pharmacy, primary health care, mental health care, and some limited additional health services. PAC also covers all family planning methods **except sterilization** because surgery and hospital services are not covered. Women can self-refer to any participating family planning provider as long as the provider agrees to bill the MCO. Additionally, under PAC the MCO must provide routine gynecologic care. PAC covers screening mammograms and pap smears; however, visits to the GYN for diagnostic tests and specialty care are not covered. PAC replaced the Maryland Pharmacy Assistance and Maryland Primary Care programs. Any Maryland resident over age 19 with very limited income and assets who does not have Medicare may be eligible. PAC services are delivered by participating primary care providers who are enrolled in managed care organizations (MCO). Managed Care Organizations participating in "PAC "include JAI, Maryland Physicians Care, and UnitedHealthcare. **PAC does not cover services such as in-patient hospital stays, outpatient hospital care, emergency room visits or visits to a specialist.**

❖ STATE ONLY and EMERGENCY MEDICAL ASSISTANCE

Effective **July 1, 2005** State-funded medical coverage ended for children under age 19 and pregnant women who are legal permanent residents, but ineligible for federal medical assistance until they have resided in the United States for at least five years as a qualified legal alien. Pregnant or postpartum women who were enrolled on June 30, 2005 remained eligible until the end of their postpartum period. Effective **November 1, 2006** Maryland Medicaid resumed coverage of children under age 19 and pregnant or postpartum women under the X01 coverage group. This State-only coverage is for qualified aliens who are ineligible for the Maryland Children's Health Program for the sole reason they do not meet the five-year residency requirement.

Ineligible or unqualified immigrants who are Maryland residents may qualify for coverage of "emergency" medical services for hospital inpatient and related services. This emergency coverage includes labor and delivery, but not routine prenatal or postpartum services for the mother. Women seeking coverage for delivery related services under the emergency provision must provide a copy of their hospital discharge summary to their local department of social services (LDSS) or health department (LHD). Pregnant women who receive medical assistance benefits under the emergency provision are ineligible for enrollment into HealthChoice. **Newborns of women covered under the emergency provision must apply for coverage by completing a MCHP application.**

❖ NEWBORN ELIGIBILITY and CLAIMS

All infants born to women with Medicaid are eligible for Medicaid coverage. Infants born to women enrolled in MCHP are eligible through their first birthday. If a pregnant woman is in an MCO at the time of delivery, her newborn is automatically enrolled in the same MCO. Women should be encouraged to choose a provider for their newborn by the eighth month of pregnancy. Please encourage her to call the Member Services Department of her MCO immediately after delivery to inform them of the provider's name. The hospital must complete a ***Hospital Report of Newborn (DHMH 1184***) and fax it to the Department of Health and Mental Hygiene, Recipient Master File Unit at 410-333-7012. Once the Department receives this form, the newborn's temporary Medical Assistance number will be sent to the birth hospital, mother's MCO, and the client's designated eligibility office at either the local health department or local department of social services. The local eligibility unit will then activate the newborn's case in the *Client Automated Resource & Eligibility System* or "CARES", which will generate a permanent Medical Assistance number for the newborn.

NOTE: When submitting claims for services rendered to newborns, providers must use the newborn's name and unique medical assistance number. **Do not use the mother's MA#.**

Each managed care organization is required to have a **Newborn Coordinator**. This individual serves as the point of contact for providers who have questions or concerns related to eligibility and the provision of services to newborns within the first 60 days of birth. Listed below is the newborn coordinator contact information for each MCO:

MCO	Newborn Coordinator's #
AMERIGROUP Maryland, Inc.	410-981-4085 Fax: 410-981-4599
Diamond Plan	443-436-3118 Fax: 443-436-3123
Helix Family Choice	410-933-2276 Fax: 410-933-2264
Jai Medical Systems	410-433-2200 Fax: 410-433-4615
Maryland Physicians Care	410-401-9608 Fax: 410-609-1860
Priority Partners	410-424-4960 Fax: 410-424-4991
UnitedHealthcare	410-540-4312 Fax: 410-540-5977

Section III

MEDICAID APPLICATON PROCESS

CITIZENSHIP and IDENTITY DOCUMENTATION

Effective July 1, 2006, federal law requires verification of citizenship and identity as a condition for Medical Assistance eligibility. The Maryland Department of Health and Mental Hygiene began implementing this new federal law on September 1, 2006. ***New*** and ***current*** recipients must provide documentation to prove citizenship and identity. **NOTE:** Documentation is not required for newborns whose mother was enrolled in MA or MCHP on the date of delivery, ***unless*** the mother was an undocumented alien and only covered for emergency medical services. Applicants and recipients who have questions about the new requirements can call 1-866-676-5880 for additional information and assistance. Further information can also be found at www.dhmh.state.md.us by clicking on the link to *Proof of Citizenship and Identity*.

Timeliness is critical to the provision of health care to pregnant women. Questions regarding MCHP or Accelerated Certification of Eligibility (ACE) can be directed to the Maternal-Child Health Information Line at 1-800-456-8900.

- **MCHP**

  - Refer all uninsured women to the local health department (LHD) eligibility unit (*Resources, B-2)* or the Maryland Children's Health Program through the Maternal-Child Health Information Line at 1-800-456-8900.

  - Effective July 1, 2001, a pregnant woman applying for coverage through MCHP will not be required to provide written proof of pregnancy. The pregnant woman's declaration that she has verified her pregnancy is acceptable.

  - A pregnant woman may mail or bring her signed application, including her expected date of delivery, to the LHD in her county of residence. Faxed copies are accepted at any of the LHD eligibility units; however the original application must be delivered with an original signature before it can be processed.

  - The LHD processes MCHP applications and in most cases eligibility is determined within ten days of receipt of a completed application.

  - Most women will be required to enroll in a managed care organization (MCO).

  - Women have 21 days from the date eligibility notification and MCO information is mailed from the Department to choose an MCO; if they fail to do so, they will be auto-assigned.

❖ ACCELERATED CERTIFICATION OF ELIGIBILITY (ACE)

- Allows the LHD to process MCHP applications for eligible pregnant women, who are also receiving social service benefits such as food stamps or cash assistance, within two working days of receipt of the application.

- The LHD can process MCHP eligibility for a 3-month period until the LDSS renders a final determination of eligibility.

- ACE allows pregnant women, who are also receiving social service benefits, to receive coverage of medical services while a final review is completed to determine eligibility for continuing benefits.

- Pregnant women certified under ACE will be enrolled in the MCO of their choice.

- Benefits will begin back to the first day of the month in which the application is received by the LHD.

- Most bills for services provided in the month prior to the patient applying for MCHP through ACE can be submitted to Medicaid for payment on a fee-for-service basis.

Section IV

ELIGIBILITY VERIFICATION SYSTEM

❖ INTRODUCTION

The Maryland Medicaid Eligibility Verification System (EVS) is a telephone inquiry system that enables health-care providers to quickly and efficiently verify a Medicaid recipient's current eligibility status.

A Medical Assistance card alone does not guarantee that a recipient is currently eligible for Medicaid benefits. You can use EVS to quickly verify a recipient's eligibility status. ***To ensure recipient eligibility for a specific date of service, you must use EVS prior to rendering service***.

EVS is fast and easy to use, and is available 24 hours a day, 7 days a week. EVS requires only seconds to verify eligibility and during each call you can verify as many recipients as you like. EVS is an invaluable tool to Medicaid providers for ensuring accurate and timely eligibility information for claim submissions.

EVS provides you with the capability of verifying past dates of eligibility for services rendered up to one year. Additionally, if the Medical Assistance number is not available, you can use the recipient's Social Security number and name code to obtain the ID number.

For providers enrolled in **eMedicaid, "WebEVS"**, a new web-based eligibility application is available. Providers must be enrolled in eMedicaid in order to access EVS. To enroll and access "WebEVS" go to www.emdhealthchoice.org. and select "Services for Medical Care Providers" and follow the login instructions. If you need information, please visit the website or for provider application support call 410-767-5340. For questions about the new EVS, please contact Provider Relations at 410-767-5503 or 1-800-445-1159.

❖ WHAT YOU NEED

- A touchtone phone
- The EVS access telephone number
- Your Medicaid provider number (NPI after July 30, 2007)
- The recipient Medicaid number and name code or social security number and name code
- Date of service, if other than current date

❖ HELPFUL TIPS

- You must press the pound key **once (#)** after entering data requested in each prompt.

- If you make a mistake, press the asterisk (*) key once. EVS disregards the incorrect information and repeats the prompt.

- If you do not enter data within a predetermined time period after a prompt, EVS re-prompts you. If you fail to enter data after the second prompt, EVS will disconnect the call.

- To end the call press the pound key twice (##) at any prompt prior to entering data. The system responds "Have a good day" and disconnects your call.

- EVS provides current information up to the previous business day. **Please listen closely to the entire EVS message before ending the call** so that you don't miss important eligibility information.

- The EVS message will give you the name and phone number of the woman's managed care organization (MCO), if she is enrolled in "HealthChoice". Providers can press "3" and the call will be transferred directly to the MCO's call center to verify primary care physician (PCP) assignment.

- The EVS message for women that have Medicaid and are "fee-for-service" (not enrolled in HealthChoice) is "**eligible, federal.**

- The EVS message for women in the Family Planning Program is "**eligible, recipient has family planning coverage only, abortion and infertility services not covered".**

- The EVS message for women in the Primary Adult Care Program under "fee-for-service" (not enrolled in an MCO) will indicate, **"recipient has pharmacy and outpatient mental health coverage only.**

- The EVS message for women in the Primary Adult Care Program (enrolled in an MCO), will indicate, "**recipient is eligible and is enrolled in a PAC MCO (identifies MCO and phone #)**

- If you have questions about the different types of eligibility, call the Maternal-Child Health Information Line at 800-456-8900.

- If you need further assistance with EVS, call Provider Relations Monday – Friday between 8:00 a.m. and 5:00 p.m. at 410-767-5503 or 800-445-1159.

❖ HOW TO USE EVS

- Call the EVS access telephone number:
  1-866-710-1447 (State-wide)

- Enter your 9 digit provider number (10 digit NPI after July 30, 2007) and press the pound key once (#)
  Example: 012345678#

- For **current eligibility** enter the 11-digit recipient number and the 2-digit name code (the first two letters of the last name converted into numeric touchtone numbers) and press the pound key once (#).
  Example: *For recipient Mary Stern, you would enter:*

  11223344556 *(recipient ID number) and* ***78#*** *(7 is for "S" in Stern and 8 is for "T" in Stern)*

NOTE: Since the characters Q and Z are not available on all touchtone phones, enter the digit **7** for the letter **Q** and digit **9** for the letter **Z**. Use a zero (0) for space if recipient has only one letter in last name. ***Example:*** *Malcolm X; name code =X0*

- EVS will respond with current eligibility information or an error message if incorrect information has been entered.

- For **past eligibility** you can search a recipient's past eligibility status for up to one year. To do a search of past eligibility, enter a date of up to one year using the format ***MMDDCCYY***
  Example: *For recipient Mary Stern, where the date of service was January 1, 1995, you would enter:*

  11223344556 *(recipient ID#) and* ***78*** *(last name code) and* ***01011995#*** *(service date)*

- EVS will respond with eligibility information for the date of service requested or an error message if incorrect information was entered.

  NOTE: Should you enter the date incorrectly, EVS re-prompts you to re-enter **only the date**; however, at the prompt, you can return to the "ENTER RECIPIENT NUMBER AND NAME CODE" prompt by pressing "9" and the pound key twice (##).

- **If the recipient number is not available:** At the recipient number prompt, press zero (0) and the pound key twice (##). EVS prompts you with the following: "ENTER SOCIAL SECURITY NUMBER AND NAME CODE". Using a recipient's SSN and name code, you may search current eligibility or optionally search past eligibility up to one year. To search past eligibility, follow the name code data entry with the date of service in MMDDCCYY format.

  Example: 111223334*(SSN) and* ***78#*** *(last name code)*

  NOTE: Social Security Numbers are not on file for all recipients. If you have entered a valid SSN, which is on file, and the recipient is currently eligible for Medical Assistance, EVS will provide you with the current eligibility status and a valid recipient number. You should record this information.

- To repeat the eligibility status, press "1"; to enter the next recipient, press "2"; to end the call, press the pound key twice (##).

- It is important to end the call by pressing the pound key twice (##) to free both your phone line and the EVS line for the next caller.

  If you need further assistance with EVS, call Provider Relations Monday – Friday between 8:00 a.m. and 5:00 p.m. at 410-767-5503 or 800-445-1159.

Section V

HEALTHCHOICE PREGNANCY RELATED SERVICES

All pregnant women must have access to early prenatal care. When a HealthChoice member suspects she is pregnant she should contact her MCO/PCP. MCOs are responsible for scheduling an appointment for the first prenatal visit and seeing the woman within 10 days of the enrollee's request.

PRENATAL SERVICES PRIOR TO MCO ENROLLMENT

❖ **SELF-REFERRAL SERVICES** (***HealthChoice Self-Referral Manual, April 2006)***

If a newly enrolled pregnant woman has already established care with an out-of-network provider and that care included a full prenatal examination, risk assessment, and appropriate laboratory tests, the MCO must pay the provider. In the event that an out-of-network provider has provided pre-enrollment care and initiated prenatal care **prior** to the pregnant woman's enrollment in an MCO, the prenatal care **provider may choose** to continue rendering out-of-network prenatal care under these self-referral provisions.

OB Providers can assist in assuring continuity of prenatal care by following the steps outlined below:

- You are encouraged to provide care to pregnant women who are in the Medical Assistance application and MCO selection process.
- If you participate in HealthChoice, let potential HealthChoice members know which MCO(s) your practice participates in and whether you will accept women for out-of-network prenatal care.
- If you participate in one or more MCO(s) and have initiated prenatal care for a pregnant woman who has Medical Assistance, but is not in an MCO, encourage her to select an MCO in which you participate. She should call the enrollment broker at 1-800-977-7388 to choose an MCO.
- You are not required to continue providing prenatal care to a pregnant woman who subsequently enrolls in an MCO in which you do not participate.
- You are encouraged to continue to see these women under the self-referral option.
- If a pregnant woman is auto-assigned to an MCO in which you do not participate, tell her to call the enrollment broker at 1-800-977-7388; she may be able to change MCOs.
- The MCO is responsible for the payment of comprehensive prenatal care for a **normal** pregnancy, including prenatal, intrapartum, and postpartum care at the established Medicaid rate and without preauthorization.

Prenatal care providers should follow these guidelines for the provision of **self-referral** pregnancy related services:

- Inform the member's MCO that you plan to continue to provide prenatal care to the member as an out-of-network provider.

- Refer the member to the MCO's OB case management services or special needs coordinator (MCOs are required to have these services for pregnant women). (*Resources, B-6*).

- Screen the member for substance abuse using a screening instrument that is (1) appropriate for the detection of both alcohol and drug abuse (2) recommended by the Substance Abuse and Mental Health Services Administration (SAMSA) of the U.S. Department of Health and Human Services, and (3) appropriate for the age of the patient. Refer to the MCO's Behavioral Health Organization, if indicated. (*Resources, B-7*).

- Complete the ***Maryland Prenatal Risk Assessment Form (*DHMH 4850)** (*Forms, page A-1*) and **promptly** forward the form to the appropriate local health department Healthy Start Program. (**Prior** to the pregnant woman's enrollment in an MCO, completion of the risk assessment is billed to MA using **billing code H1000**.

- Refer the member to the WIC Program at 1-800-242-4WIC; WIC provides information and resources on nutrition including breastfeeding.

- Providers should document in the medical record that health education and counseling appropriate to the needs of the pregnant woman was provided. The provider may then bill the MCO for an "Enriched" maternity service at each visit using **billing code H1003**.

- When consultation or referral for high-risk prenatal care is indicated, make referrals to the member's MCO network providers only.

- Bill the member's MCO for laboratory, radiology, and pharmacy services provided on-site in conjunction with pregnancy related services.

- When it is necessary to refer off-site for laboratory, radiology, and pharmacy services, use only those providers who are in the member's MCO network.

- Prior to the eighth month of pregnancy the prenatal care provider should instruct the pregnant woman to contact her MCO for assistance in choosing a provider for the newborn.

- For all non-pregnancy related medical services, refer pregnant women to their "**in network"** primary care provider (PCP).

BILLING/PROCEDURE CODES

Prenatal care providers typically bill MCOs using CPT evaluation and management codes (**99201 – 99205** and **99211 – 99215**) and two Healthy Start codes (**H1000 and H1003**). The most commonly used codes are:

CPT Code	Description	Rate
99201	Office visit, new patient, minimal	$30.27
99202	Office visit, new patient, moderate	$53.50
99203	Office visit, new patient, extended	$79.45
99204	Office visit, new patient, comprehensive	$112.14
99205	Office visit, new patient, complicated	$142.20
99211	Office visit, established patient, minimal	$18.07
99212	Office visit, established patient, moderate	$31.90
99213	Office visit, established patient, extended	$43.41
99214	Office visit, established patient, comprehensive	$67.94
99215	Office visit, established patient, complicated	$98.32
H1000	Prenatal care, at risk assessment (bill once)	$40.00
H1003	Prenatal care, at risk enhanced service education	$10.00
59410	Vaginal delivery, including postpartum care	$941.93
59515	Cesarean delivery, including postpartum care	$1124.12
59430	Postpartum care only	$148.94

MCOs are responsible for payment of circumcisions performed by an obstetrician who provided delivery services for a woman under the self-referral provision. When billing for newborn circumcisions (CPT **54150** or **54160**) you must use the newborn's name and MA number. Contact the nurse consultant in the Division of Outreach and Care Coordination at (410) 767-6750 or 1-800-456-8900 for additional information.

PRENATAL SERVICES AFTER MCO ENROLLMENT

❖ MCO SERVICES

The MCO or its contracted provider has responsibility for assuring the following for pregnant and postpartum women:

- The MCO must provide easy access to prenatal care, including an appointment for the first visit within 10 days of request.

- The MCO must assure access to appropriate levels of care including inpatient, outpatient, and emergency services. This includes providing an adequate network of providers including obstetricians-gynecologists, perinatologists, pediatricians, neonatologists, anesthesiologists, dentists and other health care providers, in order to deal with complex maternal and infant health issues. The provision of appropriate emergency transfer of pregnant women and newborns to tertiary facilities, when necessary, is also required.

- The MCO must assure that the prenatal care provider completes **the *Maryland Prenatal Risk Assessment (DHMH 4850)*** at the first prenatal visit. The provider must forward the risk assessment, within 10 days after completion, to the LHD Healthy Start Program in the county in which the woman resides. **NOTE:** Completion of the Maryland Prenatal Risk Assessment is required for all Medicaid patients including those enrolled in an MCO. Check with your MCO (s) about their reimbursement policy for completion of the risk assessment form, as the MCO may consider this service to be part of their fee. If you are uncertain about your MCO's policies or have billing questions, contact the MCO's Provider Relations Department. (*Resources, B-6*).

- The MCO must refer women identified as high risk, based on the risk assessment screening, to the Healthy Start Care Coordination Program located at the LHD in the county in which the pregnant woman resides. (See page 31 for additional information on Healthy Start services).

- The MCO must assure that risk-related education is provided including smoking cessation education; nutrition education; drug and alcohol education; HIV/STI education, and contraceptive options counseling.

- The MCO must refer pregnant women to the WIC Program at 800-242-4WIC.

- The MCO must provide an appropriate level of substance abuse services, including comprehensive services, when indicated, for pregnant substance abusers. These services must include specialized intensive day treatment that allows for children to accompany their mother.

- The MCO must follow ACOG standards for determining frequency of visits, including care beginning in the first trimester with visits every four weeks for the first 28 weeks of pregnancy; every two weeks for the next eight weeks and weekly thereafter until delivery.

- The MCO must link the pregnant woman with a pediatric provider, prior to the eighth month of pregnancy.

- The MCO must ensure coordination of care or access to case management, as appropriate. Each MCO has prenatal programs available offering outreach and education to pregnant members, the goals of which are to encourage compliance, manage problems, and reduce negative outcomes. Additional information about MCO prenatal programs can be obtained by contacting the following:

MCO	**Phone Number**
AMERIGROUP Maryland, Inc.	800-964-2112
Diamond Plan	800-727-9951
Helix Family Choice	800-905-1722
Jai Medical Systems	888-524-1999
Maryland Physicians Care	800-953-8854
Priority Partners	888-500-8786
UnitedHealthcare	800-487-7391

- The MCO must provide postpartum care and access to all family planning options, including tubal ligations. A consent form must be signed at least 30 days prior to the sterilization. All providers are required to complete Maryland Medicaid's ***Sterilization Consent Form (DHMH 2989).***

Section VI

MEDICAID FEE-FOR-SERVICE PROCEDURES

A. PRENATAL CARE

Pregnant women, prior to enrollment in the MCO or some populations not eligible for enrollment into HealthChoice, may access care on a "fee-for-service" basis.

PROCEDURES

- The Medicaid Program does not reimburse physicians for "global" maternity care services. Maryland Medicaid does not use CPT codes 59400, 59510 and 59610. Providers must bill deliveries separately from prenatal care. This is discussed on page 23 under Maternity and Postpartum Services.

- The Maryland Medical Assistance Program no longer uses antepartum codes 59425 and 59426. These codes were previously payable at the rate of $32.00 per visit; they were used as separate encounters rather than as a group of visits as described in CPT. Under the Health Insurance Portability and Accountability Act (HIPAA) Maryland Medicaid is required to use nationally recognized procedure codes. Prenatal care providers should use the appropriate evaluation and management code for each prenatal visit. The evaluation and management codes with applicable rates are as follows:

CPT Code	Description	Rate
99201	Office visit, new patient, minimal	$30.27
99202	Office visit, new patient, moderate	$53.50
99203	Office visit, new patient, extended	$79.45
99204	Office visit, new patient, comprehensive	$112.14
99205	Office visit, new patient Complicated	$142.20
99211	Office visit, established patient, minimal	$18.07
99212	Office visit, established patient, moderate	$31.90
99213	Office visit, established patient, extended	$43.41
99214	Office visit, established patient, comprehensive	$67.94
99215	Office visit, established patient, complicated	$98.32

Indicate the appropriate diagnosis code: **V22** for normal pregnancy or **V23** for high-risk pregnancy on claims submitted related to prenatal care visits.

- Medicaid pays for medically necessary services related to prenatal care such as lab tests, prenatal vitamins and prescription drugs, sonograms, and non-stress tests. Use the appropriate CPT codes for ancillary services.

SERVICES

- ***Maryland Prenatal Risk Assessment***
  Maryland Medicaid pays prenatal care providers $40.00 in addition to the prenatal visit fee, for completion of the Maryland Prenatal Risk Assessment Form (*Forms, page A-1*). The billing code for this service is **H1000**. You may only bill for one risk assessment charge per pregnancy.

- Complete the Maryland Prenatal Risk Assessment Form at the initial prenatal visit. Within 10 days of this initial visit forward the form to the local health department (LHD) Healthy Start Program in the county where the pregnant woman resides (*Resources, page B-3*). Completion of the risk assessment is important because it assists in identifying women at risk for low birth weight or pre-term delivery. These women are given priority for Healthy Start Services in those counties unable to provide services to all women with Medicaid.

- ***Enriched Maternity Services***
  Medicaid will pay providers an additional $10.00 fee when "enriched" maternity services are provided at each office visit to an eligible recipient. These services may include:

  *Counseling
  *Health education
  *Nutrition education
  *Care coordination
  *Contraceptive counseling
  *Referrals to services such as WIC, smoking cessation, and alcohol or substance abuse treatment services.

  All pregnant women with Medicaid can benefit from "enriched" maternity services regardless of risk status. We ask that you provide the scope of service appropriate to the woman's individual level of need. Documentation must be noted in the medical record to support that health education and counseling appropriate to the needs of the pregnant woman was provided in order to bill for this service. We offer a format (*Forms, page A-2*) that can be photocopied for use to document these "enriched" maternity services. Providers may bill for an "enriched" maternity service at each visit using billing code **H1003**. For additional information call the Division of Outreach and Care Coordination at 410-767-6750 and ask to speak with a nurse consultant.

An example of a prenatal visit with a new patient:	
Evaluation/Management (**99202 – 99205**)	$53.50 to $142.20
Prenatal care, at risk assessment (**H1000)**	$40.00
Prenatal care, at risk enhanced service education (**H1003**)	$10.00
An example of a prenatal visit with an established patient:	
Evaluation/Management (**99211 – 99215**)	$18.07 to $98.32
Prenatal care, at risk enhanced service education (**H1003)**	$10.00

B. MATERNITY AND POSTPARTUM SERVICES

BILLING PROCEDURES

Vaginal Delivery
Maryland Medicaid will reimburse for vaginal delivery, including postpartum care as a separate procedure, CPT code **59410**. When you submit a CMS-1500 for a delivery which includes other procedures on the same date of service, make sure the CPT code for the delivery is listed on the first line of *Block 24* to ensure proper payment. Place a modifier in *column 24D*, for the second or subsequent procedure on the same date of service.

NOTE: Physicians and nurse midwives should bill for vaginal deliveries including postpartum care performed in a home or birthing center using CPT codes **59410** and **59614** with the appropriate place of service, **12** or **25**, indicated in *Block 24B* of the CMS-1500. The reimbursement rate for a vaginal delivery in a home setting is $1054 and $1395 in a birthing center. Providers should bill the unlisted maternity care and delivery code **59899** for supplies used during a vaginal delivery in a home or birthing center. The fee for delivery supplies is $75. Refer to the *Medical Assistance Physicians Fee Manual and CMS-1500 Billing Instructions* or call Provider Relations at 410-767-5503 or 800-445-1159 for additional billing information.

Cesarean Delivery
Cesarean deliveries must be billed as a separate procedure, using CPT code **59515**. When you submit a CMS-1500 claim for a cesarean birth which includes other procedures on the same date of service, make sure the CPT code for the cesarean is listed on the first line of *Block 24*. Place a modifier in *column 24D* for the second or subsequent procedure.

A tubal ligation performed at the time of a cesarean delivery must be billed separately using procedure code **58611** with a modifier -51 and include the ***Sterilization Consent form (DHMH 2989)***.

Postpartum Care
Maryland Medicaid will pay for postpartum care only using CPT code **59430**. Postpartum care includes all the visits after the delivery, in the hospital and the office. Postpartum care is not payable as a separate procedure, unless it is provided by a physician or group other than the one providing the delivery service.

C. HOSPITAL ADMISSIONS

Pre-authorization by Keystone Peer Review Organization, Inc. (KēPRO) the Program's Utilization Control Agent (UCA) is required for all elective hospital admissions for recipients covered under Medicaid's fee- for-service program. It is the hospital's responsibility to obtain pre-authorization by calling KēPRO at 866-581-6773. Questions concerning hospital services should be directed to 410-767-1722.

D. GYN SERVICES

Annual gynecologic exams for asymptomatic patients should be billed using preventive medicine codes **99383** – **99387** for new patients or **99393 – 99397** for established patients. Please note that the Pap smear is considered part of the office visit, and may only be billed by the laboratory that reads and interprets the test. The appropriate evaluation and management codes to be used for symptomatic patients are **99201 - 99205** for new patients or **99211- 99215** for established patients.

❖ *Women's Breast and Cervical Cancer Health Program (WBCCHP)*

In April 2002 Maryland Medicaid implemented the *Women's Breast and Cervical Cancer Health Program* to provide Medical Assistance coverage for **women who have been screened through the Breast and Cervical Cancer Program (BCCP) and diagnosed with breast or cervical cancer.** In order to qualify for the program, women must:

- Not be eligible for Medicaid or Medicare
- Be between the ages of 40 and 64 years old;
- Be a Maryland resident;
- Be uninsured, or have insurance that does not cover cancer treatment;
- Be in need of treatment and;

For additional information, you may contact the *Breast and Cervical Cancer Program* at your local health department (*Resources, B-5).*

❖ *Hysterectomy Services*

Medicaid will reimburse for a hysterectomy under the following conditions:

- The physician who obtained authorization to perform the hysterectomy has **informed the individual** and her representative, if any, **orally and in writing**, that the **hysterectomy will render the individual permanently incapable of reproducing**, and

- The **individual** or her representative, if any, **has signed a written acknowledgement of receipt of that information**, or

- The individual was already sterile before the hysterectomy, or

- The individual requires a hysterectomy because of a life threatening emergency and the physician determines that prior informing and acknowledgement are not possible, and

- The physician who performs the hysterectomy (1) certifies, in writing via the ***Document for Hysterectomy (*DHMH 2990)** (*Forms, page* A-5) that the individual was already sterile at the time of the hysterectomy and states the cause of the sterility, or (2) certifies, in writing, that the hysterectomy was performed under a life-threatening emergency situation in which the physician determines that prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency.

- **NOTE:** Regulations require the physician who performs the hysterectomy (not a secondary provider such as an assisting surgeon or anesthesiologist) to certify that the woman met one of the specified exemptions. Patient consent (signature) is not required if the patient is over age 55.

- **NOTE:** A separate CMS-1500 claim must be submitted accompanied by the ***Document for Hysterectomy (DHMH 2990).***

The following CPT codes should be used when billing Maryland Medicaid for hysterectomy procedures:

Procedure Code	Rate	Procedure Code	Rate	Procedure Code	Rate
51925	$408.00	**58267**	$1065.48	**58550**	$900.56
58150	$952.48	**58270**	$893.88	**58552**	$999.79
58152	$1275.50	**58275**	$986.03	**58553**	$1171.44
58180	$947.55	**58280**	$439.00	**58554**	$438.06
58200	$1322.07	**58285**	$1352.17	**58951**	$1374.23
58210	$1759.24	**58290**	$1179.67	**58953**	$693.52
58240	$2335.10	**58291**	$483.42	**58954**	$745.84
58260	$824.42	**58292**	$511.98	**59135**	$356.00
58262	$928.93	**58293**	$531.72	**59525**	$527.75
58263	$439.00	**58294**	$471.24		

E. *FAMILY PLANNING SERVICES*

Women should be encouraged to choose a contraceptive method following their delivery. Women who lose their pregnancy related coverage (MCHP) after the 60-day postpartum period receive the **"**purple and white**"** Medical Assistance **Family Planning** card**.** This card covers contraceptive and family planning services only.

We encourage you to retain the women you have delivered, as patients, for contraceptive management. If you are unable to do so, please refer them to a Local Health Department, Planned Parenthood Clinic, or Community Health Center, also referred to as Federally Qualified Health Center "FQHC" (*Resources, B-8*). Women can also obtain a list of family planning resources, by calling the Maternal-Child Health Information Line at 800-456-8900.

Community Health Centers provide primary healthcare and offer a range of services such as treatment of chronic conditions (i.e.: hypertension or diabetes), office visits for sick and well care, basic laboratory tests and x-rays, screenings and referrals to alcohol and drug addiction services, and referrals for mental health care. Providers are encouraged to refer women who have "family planning only" coverage in need of primary health services to one of these health centers.

Self Referral Services

Family planning services provide individuals with the information and means to prevent untimed pregnancy and maintain reproductive health, including medically necessary and appropriate office visits and the prescribing of contraceptive devices. Federal law permits Medicaid recipients to receive family planning services from any qualified provider. HealthChoice members may self-refer for family planning services without prior authorization or approval from their PCP, with the exception of sterilization procedures (***HealthChoice Self-Referral Manual, April 2006***).

The scope of services covered under the "self-referral" provision is limited to those services required for contraceptive management. The diagnosis code **(V25)** must be indicated on the claim form in order for the MCO to recognize that the preventive medicine or E&M code is related to a family planning service.

NOTE: Women enrolled in the Primary Adult Care Program (PAC) are eligible for all family planning options, except sterilization. Those women desiring sterilization should call 1-800-456-8900.

Maryland Medicaid Family Planning Program

Maryland Medicaid currently has a family planning waiver (COMAR 10.09.58) which allows the state to provide a limited benefits package of family planning services to women who lose full medical assistance coverage following a pregnancy related period of eligibility. Pregnancy related coverage (MCHP) ends two months after delivery at which time she is no longer enrolled in the managed care organization (MCO). These women are automatically enrolled in the Maryland Medicaid **Family Planning** Program and issued a "purple and white" Medicaid card. This card covers contraceptive and family planning services only.

Women who began their family planning coverage **prior to July 1, 2003** will have five years of continuous coverage unless they **1**) move out of the State of Maryland, **2**) change their eligibility status by obtaining coverage in another MA eligibility category, **3**) obtain a tubal ligation, **4**) contact Maryland Medicaid and ask to be removed from the program.

Women obtaining coverage **on or after July 1, 2003** receive two years of continuous coverage and must complete a financial renewal process in order to continue receiving benefits under the **Family Planning** Program. Currently a renewal process must be completed annually until the women reach the end of their five-year eligibility period. Women can be cancelled prior to the end of their eligibility period for any of the reasons indicated above, or if they: exceed the qualifying family income level of 250% of federal poverty or fail to respond to written requests for income information.

SERVICES/SUPPLIES

Maryland Medicaid's **Family Planning Program** covers services related to birth control only, including but not limited to medically necessary office visits, laboratory tests, all FDA-approved contraceptive devices, methods, and supplies and voluntary sterilizations (tubal ligation).

- Abortions and hysterectomies are not considered family planning services and are not covered for women with the "purple and white" card enrolled in only the **Family Planning Program**

The Program reimburses providers for family planning services, including office visits (CPT codes 99201 - 99205 and 99211 - 99215), preventative medicine office visits (CPT codes 99383 - 99386 and 99393 – 99396), and all FDA-approved contraceptive devices, methods, and supplies, at the established Medicaid rates. Family planning services should be billed using a separate CMS-1500.

Commonly used family planning methods covered by the Program include:

Contraceptive creams, foams, and jellies - A prescription is required to obtain these products.

Condoms - Recipients can obtain 12 latex condoms from the pharmacy without a prescription.

Depo-Provera - CPT code **J1055** should be used for billing when the drug is supplied from the provider's inventory. **NOTE:** The cost of administering the drug is included in the office visit; therefore a separate medication administration fee cannot be billed.

Oral Contraceptives - A maximum six-month supply may be dispensed per prescription. **Effective October 15, 2004** prescribers must complete a Food and Drug Administration (FDA) *MedWatch form* and forward a copy to the Maryland Pharmacy Program for review before the Program will reimburse at the "brand" rate for prescriptions dispensed as "brand medically necessary". A copy of the *MedWatch form* can be obtained from the Maryland Pharmacy Program website at http://dhmh.state.md.us/mma/mpap/fda.htm.

Intrauterine Devices - Products should be billed using CPT code **J7300** or **J7302** for the copper IUD and Mirena®, respectively. CPT codes **58300-58301** should be billed for insertion and removal.

Diaphragm - CPT code **A4266** should be billed for the product and **57170** for fitting with instructions. A copy of the invoice must be attached to the claim.

Cervical Cap - CPT code **A4261** should be billed with a copy of the invoice attached to the claim.

Contraceptive Hormone devices – Use CPT code **J7303** for the contraceptive hormone vaginal ring and **J7304** for the contraceptive hormone patch. A copy of the invoice must be attached to the claim for these products.

NOTE: Contraceptive products not listed above should be billed using CPT code **99070.** A copy of the invoice must accompany the invoice for the following products: **99070, A4266, J7303, J7304, and S0180.**

Implanon™

In July 2006, the FDA approved Implanon™, a long-acting birth control method that is implanted in the upper arm. Implanon™, a single rod about the size of a matchstick is placed beneath the skin with a local anesthetic. *Organon,* the product's manufacturer requires providers be trained in its' insertion and removal before they can order the product for distribution. The product should be billed using CPT code **S0180** with a copy of the invoice attached to the claim. Fees will be based on the provider's acquisition cost. CPT codes **11981-11983** should be billed for the insertion, removal or removal with reinsertion.

Emergency Contraception - Plan B®

Emergency contraception is a second chance to help prevent an unplanned pregnancy following contraceptive failure, unprotected sex, or sexual assault. Plan B® was approved by the FDA for prescription use in July 1999. In August 2006, it was approved for over the counter (OTC) use. OTC sales are restricted to individuals age 18 or older. A valid government-issued ID must be presented for age verification. **Individuals age 17 and younger must have a valid prescription.**

Oral Prescriptions under Medicaid

Effective **October 1, 2006**, a new state law allows Maryland Medicaid pharmacists to accept oral prescriptions from prescribing providers over the phone for Medicaid recipients. All information required by federal and state law must be included on the prescription. **NOTE:** Phone-in prescriptions will not be allowed for Schedule II controlled substances. Any questions should be directed to the Division of Pharmacy Services at 410-767-1455.

- ***Please note:*** Medicaid's **Family Planning Program** covers services related to birth control only. Diagnostic and treatment services for infertility, gynecological, or HIV-AIDS related conditions or cancer are not covered under the **Family Planning Program.** Women in need of primary care services should be referred to a Federally Qualified Health Center (*Resources, B-8)*. Services are provided based on one's ability to pay. Women may also obtain information by calling the Maternal-Child Health information line at 1-800-456-8900.

F. STERILIZATIONS/TUBAL LIGATIONS

The Program will reimburse for sterilizations, including tubal ligations, if the following conditions are met:

1. The individual is at least 21 years old at the time consent is obtained,

2. The individual is not mentally incompetent,

3. The individual is not institutionalized,

4. The individual has voluntarily given informed consent as described in Part I of the consent document, ***Sterilization Consent Form*** (***DHMH 2989***), and

5. At least 30 days, but no more than 180 days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization.

In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. Providers **must obtain pre-authorization** from the MCO for HealthChoice members before any sterilization procedure is performed.

Sterilization/tubal ligation procedures must be billed on a separate CMS-1500. If the procedure was performed on the same date of service as another procedure, a modifier is required in *Block 24D* for the second or subsequent procedure. The ***Sterilization Consent Form- DHMH 2989*** (*Forms, page A-3, A-4*) must accompany all invoices for sterilization (CPT codes **58565**, **58600-58615, 58670, 58671, and 58700**).

- **NOTE:** An individual is not eligible for the sterilization procedure until the 32nd day after giving consent (signature date). Women who obtain a tubal ligation are no longer covered for any services under the family planning program.

Essure®

In November 1992, the FDA approved Essure® an alternative for women who desire permanent birth control (female sterilization) by bilateral occlusion of the fallopian tubes. The Essure® procedure requires no incisions and can be performed without general anesthesia. Three months after the procedure, women must undergo a hysterosalpingogram to confirm the micro-inserts are properly placed and tubal occlusion has occurred.

Effective **January 1, 2005** the AMA has established a new level 1 CPT code for the procedure: **58565**-Hysteroscopy, surgical; bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. CPT code **58340** should be used for HSG testing post procedure. The diagnosis code V25.40 should be indicated on the claim to denote the test is for proof of occlusion not fertilization.

G. PREGNANCY TERMINATION

The Program covers pregnancy termination; however Medicaid does restrict coverage, as required by state law. Under fee-for-service, Medicaid will reimburse providers if one of the conditions listed below exists:

(1) A continuation of pregnancy is likely to result in the death of the woman;
(2) The woman is a victim of rape, sexual offense, or incest.
(3) It can be ascertained by the physician within a reasonable degree of medical certainty that the fetus is affected by genetic defect or serious deformity or abnormality.
(4) It can be ascertained by the physician within a reasonable degree of medical certainty that termination of the pregnancy is medically necessary because there is a risk that continuation of the pregnancy could have a serious and adverse effect on the woman's present or future physical health.
(5) Continuation of the pregnancy is creating a serious effect on the woman's present mental health and if carried to term a serious effect on the woman's future mental health.

- **NOTE:** Pregnancy terminations are not covered for women, who were determined eligible through MCHP (based on pregnancy) or the Primary Adult Care Program.

The ***Certification of Abortion*** **(DHMH 521)** (*Forms, page A-6*) must be included with the invoice submitted to Medicaid by the provider, hospital, or clinic for services related to pregnancy termination (except spontaneous abortion or treatment of ectopic pregnancy) or for medical procedures necessary to voluntarily terminate a pregnancy for victims of rape or incest. These include surgical CPT codes **59840, 59841, 59850 - 59852, and 59855 – 59857**, **59866**.

❖ *Medical Abortion: Termination of Early Pregnancy with Mifepristone (Mifeprex®)*

The Program covers on a fee-for-service basis, the administration of Mifepristone also known as "RU-486", as a medical termination procedure. CPT code **99199** "unlisted special service or procedure" should be used for billing purposes. The fee for this service is based upon three office or clinic visits over a two-week period for administration of the drug and appropriate follow-up, and the actual cost of the drugs. Physicians may not bill for office visits in addition to procedure code 99199.

"Medical Abortion" must be written on the CMS-1500 below the procedure code in *Block 24D*. Diagnosis code **635 "legally induced abortion"** or **638 "failed attempted abortion"** must be entered on *Line 1 of Block 21*. Coverage is limited to the same medical reasons as for surgical terminations and a completed *Certification of Abortion* (DHMH 521) must be attached to the claim. The date of service on this form and the CMS-1500 is the date that the patient signs the required Patient Agreement and takes orally the 600 mg of mifepristone.

For recipients enrolled in an MCO, the Medicaid Program will provide coverage for:

a. Pregnancy termination procedures
b. Related services provided at a hospital on the day of the procedure or during an inpatient stay, or
c. A pregnancy termination package as may be provided by a freestanding clinic.

The MCO, however, is financially responsible for any related services, not indicated above that may be performed as part of a medical evaluation prior to the actual performance of a pregnancy termination for which the physician who performs the procedure completes a *Certification for Abortion Form (DHMH 521)*.

The following CPT codes should be used when billing Maryland Medicaid for services related to pregnancy termination:

Procedure	Rate	Procedure	Rate
59840	$131.00	**59855**	$177.00
59841	$131.00	**59856**	$206.00
59850	$177.00	**59857**	$294.00
59851	$206.00	**59866**	$131.00
59852	$294.00	**99199**	$401.00

Section VII

HEALTHY START CARE COORDINATION SERVICES

The Department of Health and Mental Hygiene implemented the **Maryland Healthy Start Program** in response to Maryland's infant mortality rate. The current public health model works together with the managed care organizations' outreach, prenatal and medical management programs and services.

The goals of the program are to improve birth outcomes for Medicaid eligible women and reduce infant mortality by identifying and addressing predictors of poor birth outcomes and poor child health. Home visiting and early interventions are the cornerstones of the Healthy Start Program. Local health departments are the service providers for the Healthy Start Program and provide home visiting and care coordination services to "at risk" pregnant, postpartum, and child recipients to ameliorate problems and improve utilization of the health care system, and assist with adherence to the medical plan of care.

Healthy Start staff assists participants to access and utilize the managed care system and other health-related services; to practice healthy behaviors; and to utilize good parenting skills. Most pregnant women and children under the age of two with Medical Assistance, including those enrolled in HealthChoice, are potentially eligible for Healthy Start services.

Prenatal Referral Sources:
The ***Maryland Prenatal Risk Assessment Form (DHMH 4850)*** is one referral source. Prenatal care providers must complete the *Maryland Prenatal Risk Assessment Form* during the initial prenatal visit. Other referral sources may include identification of potentially eligible women through community outreach efforts such as:

- *Local Health Services Request Form (DHMH 4582)* from the MCO/Provider
- *Self- referral*

Child Referral Sources:
Frequent referral sources for children under the age of two years include:

- *Infant Identification Referral Form (DHMH 4349) from hospitals*
- *Local Health Services Request Form (DHMH 4582) from the MCO/PCP*

Please contact your local health department Healthy Start Program to find out what services are available for the prenatal and child (less than two years of age) populations in your community. The list of Healthy Start contacts is located on page *B3* of "*Resources*" located at the back of the manual.

Medical case management is the responsibility of the managed care organizations. The MCO retains full responsibility for the medical management of its HealthChoice enrollees. High-risk obstetrical home care for women with medical conditions/risks is the responsibility of the MCOs. These services, which are frequently ordered for pregnant women in need of hypertension, diabetes, and pre-term labor management, are the responsibility of the MCO.

Healthy Start staff work closely with medical providers, the MCO, and other health related and social service providers to ensure participants are linked with appropriate resources and to facilitate effective care coordination. Local health departments will advise the provider of the recipient's participation in Healthy Start and share relevant health information. The LHD collaborates with the MCO's high risk/special needs coordinator to coordinate services for program participants.

Effective coordination requires partnering with the medical providers, the MCO, and other health and social services providers.

The Program will focus on the following results:

1. Healthy mothers;
2. Babies born healthy;
3. Healthy families with access to health care;
4. Children ready to learn;
5. Families safe in their homes and communities;
6. Stable families moving toward economic self-sufficiency

Additional information on the Healthy Start Program including referrals can be obtained by contacting the local health department in your county *(p. B3, Resources)* or Medicaid's Division of Outreach and Care Coordination at 410-767-6750.